

**Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees
Virginia Advisory Committee***

November 15, 2012, from 1:00 to 4:00 pm

NEW LOCATION: Virginia General Assembly Building, House Room D

Meeting 1

I. Welcome and Introductions	Cindi Jones, Director, Virginia Department of Medical Assistance Services (DMAS)	1:00-1:15 pm
II. National Updates	Julie Klebonis, Program Officer, Center for Health Care Strategies (CHCS)	1:15-1:30 pm
III. Virginia Updates	Karen Kimsey, Director of Policy and Research, DMAS	1:30-1:45 pm
IV. Questions on National and Virginia Updates from the Advisory Committee	J. Klebonis and K. Kimsey	1:45-1:55 pm
V. Overview of Focus Sessions	Greg Howe, Deputy Director, Medicaid Leadership Institute, CHCS	1:55-2:00 pm
VI. Committee Member Focus Session I: <i>Access to Care and Provider Networks</i> Overview: <ul style="list-style-type: none"> • Medical providers (Medicare) • Pharmacy providers (Medicare) • Long-term care providers (agency) • Long-term care (consumer directed) • Behavioral health providers • Review of planned priorities for providers Share your priorities for: <ul style="list-style-type: none"> • Travel time and distance • Choice of providers • Consumer Direction • Additional recommendations 	Suzanne Gore (DMAS) and J. Klebonis (CHCS)	2:00-2:35 pm
BREAK		2:35-2:45 pm

<p>VII. Committee Member Focus Session II: <i>Education and Outreach</i></p> <p>Overview of Stakeholders:</p> <ul style="list-style-type: none"> • Beneficiaries • Families/caregivers • Providers • Community organizations (e.g., clergy, senior groups, advocates) • Local partners (AAAs, DSS, CSBs, CILs, others) • Other state agencies <p>Share your thoughts on:</p> <ul style="list-style-type: none"> • Best modes of communication to reach various stakeholder groups • Timing of outreach efforts • Additional recommendations 	<p>K. Kimsey (DMAS) and Meredith Lee (DMAS)</p>	<p>2:45-3:20 pm</p>
<p>VIII. Committee Member Focus Session III: <i>Quality Assurance</i></p> <p>Overview:</p> <ul style="list-style-type: none"> • CMS core measures • 1915(c) EDCD waiver measures • Ensuring and measuring satisfaction <p>Share your thoughts:</p> <ul style="list-style-type: none"> • Do core and EDCD measures seem sufficient? • Should DMAS require a 12th optional Model of Care Measure? If yes, what should it be? • What other state measures should be included, if any? 	<p>G. Howe (CHCS) and Paula Margolis (DMAS)</p>	<p>3:20-3:50 pm</p>
<p>IX. Wrap Up and Next Steps</p>	<p>Cindi Jones</p>	<p>3:50-4:00 pm</p>

*The Department will not hold a public comment period during this meeting; however, stakeholder input is very important to the Department and the Advisory Committee. If you have follow up questions or comments that you would like discussed during a future meeting, please submit them to Dualintegration@dmass.virginia.gov.



Improving Care for Medicare-Medicaid Enrollees: National Update

November 15, 2012

Julie Klebonis, Program Officer
Center for Health Care Strategies

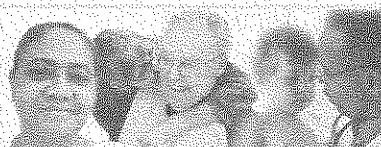
www.chcs.org

CHCS Mission

To improve health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

Our Priorities

- ▶ Enhancing Access to Coverage and Services
- ▶ Improving Quality and Reducing Racial and Ethnic Disparities
- ▶ Integrating Care for People with Complex and Special Needs
- ▶ Building Medicaid Leadership and Capacity



Current CHCS Engagement with States

- **Integrated Care Resource Center (ICRC)**
 - Contract with the Medicare-Medicaid Coordination Office
 - Partnership with Mathematica Policy Research
 - Provide technical assistance (TA) to states: AZ, CA, CO, HI, IA, ID, IL, MA, MI, MN, NY, OH, OK, OR, SC, TN, VA, VT, WA
 - www.integratedcareresourcecenter.com
- **State Planning for a High Performance System for Dual Eligibles and Managed Long-Term Services and Supports**
 - Funded by The SCAN Foundation and The Commonwealth Fund
 - Convene quarterly in-person meetings and monthly calls
 - Provide TA to states: AZ, CA, CO, GA, MA, MN, NJ, NV, OK, OR, PA, RI, SD, TN, VA, VT, WA, WI

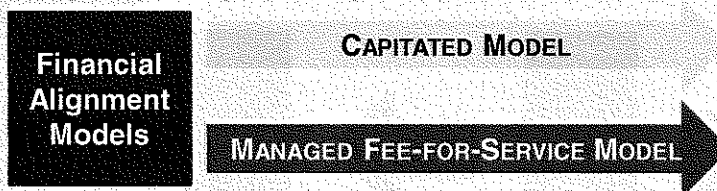
Medicare-Medicaid Coordination Office (MMCO)

- MMCO created by Section 2602 of the ACA
- Improve coordination between the Federal government and states for Medicare-Medicaid enrollees
- Focuses on:
 - Program alignment; data and analytics; and models and demonstrations
- Developed two initial opportunities for states:
 - State Demonstrations and Financial Alignment Models



New Opportunities: Financial Alignment Models

- State Medicaid Director Letter, July 8, 2011
- Offers states two paths (aka "Financial Alignment Models"):



- Open to all states – but must pursue one of the two models
- State letter of intent was due October 1, 2011, 38 states responded
- 26 states ultimately submitted design proposals to CMS to officially move forward (due May 31, 2012).
- Up to 2.8 million beneficiaries included in demonstration proposals.

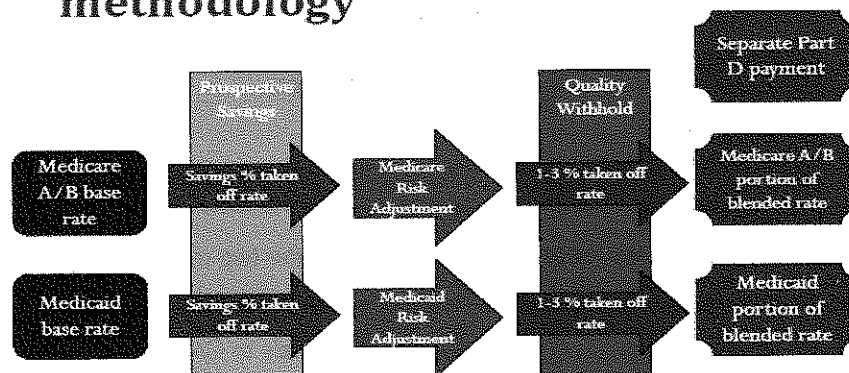
Next Steps for States

- States submitted proposals (May 2012)
- State-based procurement process
 - CA, IL, OH, and MA have selected plans
- Memorandum of Understanding development with CMS
 - MA (capitated) and WA (MFFS) have signed MOUs
- Rate development with CMS
- CMS Medicare and Medicaid Authority

Integrated Rate Development

(K. Sharaf, Oregon Office of Health Policy and Research)

Overview of CMS rate-setting methodology



Based on CMS memo, "Joint Rate-Setting Process Under the Capitated Financial Alignment Initiative," May 2012

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7

State Participation

(as of November 8, 2012)

	State	Signed MOU	Target Launch Year	Model
1	AZ	No	2014	Capitated
2	CA	No	2013	Capitated
3	CO	No	2013	MFFS
4	CT	No	2013	MFFS
5	HI	No	2014	Capitated
6	ID	No	2014	Capitated
7	IL	No	2013	Capitated
8	IA	No	2013	MFFS
9	MA	Yes	2013	Capitated
10	MI	No	2013	Capitated
11	MN	No	2013	Demo
12	MO	No	2014	MFFS

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8

State Participation (as of November 8, 2012)

	State	Signed MOU?	Target Launch Year	Model
13	NY	No	2014	Both
14	NC	No	2013	MFFS
15	OH	No	2013	Capitated
16	OK	No	2013	MFFS
17	OR	No	2014	Capitated
18	RI	No	2014	Both
19	SC	No	2014	Capitated
20	TN	No	2014	Capitated
21	TX	No	2014	Capitated
22	VT	No	2014	Capitated
23	VA	No	2014	Capitated
24	WA	Yes for MFFS	2013 (MFFS) 2014 (Cap)	Both
25	WI	No	2013	Demo

Challenges & Opportunities of Integrated Care Demonstration



CHALLENGES

- Multitude of operational, administrative, oversight, and financial issues to work out
- Aligning Medicare and Medicaid requirements
- Timeline needed to be extended to ensure program success and coincide with Medicare Advantage timelines (to decrease confusion)
- The MMCO is trying to allow flexibility, but flexibility within Medicare rules is limited
- Delays in releasing guidance regarding this demonstration
- Working through a feasible rate methodology

Challenges & Opportunities of Integrated Care Demonstration

OPPORTUNITIES

- Creates **one accountable entity** to coordinate delivery of primary/preventive, acute, behavioral, and long-term services and supports
- Promotes the use of **home- and community-based services**
- Promotes and measures **improvements in quality of life and health outcomes**
- Blends/aligns services and financing to streamline care and **eliminate cost shifting**
- Provides **high-quality, person-centered care**



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Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

Virginia Updates

November 15, 2012


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Virginia's Dual Eligible Proposal

- Submitted to CMS on May 31, 2012
- http://dmasva.dmas.virginia.gov/Content_atc_hs/altc/altc-icp5.pdf
- Under review by CMS; Virginia responding to their questions as they arise
- Target implementation date remains January 1, 2014

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Proposal Outline

- **Virginia's model:**
 - **Geographic areas** - Four regions of the state in 2014 expanding to an additional region in 2015
 - **Delivery Model** – Capitated; 2-3 Managed Care Organizations in each region
 - **Population** –adult, full benefit duals, including individuals enrolled in the Elderly and Disabled with Consumer Direction waiver and individuals in nursing facilities. Estimate 65,415 individuals eligible for enrollment in the first year
 - **Enrollment** – Passive with opt out option

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Proposal Outline Continued

- **Virginia's model:**
 - **Services** – Medicare Benefits (A, B, D); state plan primary and acute care services, including behavioral health; person-centered care coordination; LTSS waiver services; supplemental or enhanced benefits (e.g. vision, hearing) will be at MCO's option
 - **Reimbursement** – Blended, risk adjusted rate based on Medicaid, Medicare, and Medicare Advantage data. Savings adjustments taken 'off the top' and premium withholds to be paid to MCOs that meet quality performance thresholds
 - **Stakeholder involvement** – Meetings, emails and website, advisory group required through legislation

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Activities Underway

- Medicaid rate setting (working with our actuary)
 - Will provide to CMS when it is complete
- Seeking federal authorities to operate demonstration
 - 1932(a) State Plan option
 - Amending the 1915(c) waiver authority for the EDCD Waiver

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Activities Underway (Continued)

- Completed and submitted a matrix outlining program components to CMS – how Virginia thinks it should operate
 - Enrollment
 - Network adequacy
 - Appeals
 - Quality
- Creation of a Care Coordination Office within DMAS



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Activities Underway (Continued)

- Developing a Medicaid Memo to alert providers of the demonstration and to let them know Health Plans may be reaching out to them to include them in their proposed networks
 - Proposed networks are due to CMS mid February 2013
- Developing the Request for Applications
 - Goal to post RFA at the beginning of 2013

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We Want to Keep You Involved!

- DMAS will be leveraging strong relationships to move from program design to implementation

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Ongoing Stakeholder Input

- DMAS established the Advisory Committee pursuant to a directive in the 2012 Appropriations Act (Item 307 RR.g)
- DMAS will work with this committee and other stakeholders to ensure that this program best meets the needs of dual eligible enrollees in Virginia

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9



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Access to Care and Provider Networks

November 15, 2012


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Provider Types

- Long-term care providers
 - Agency (personal care, respite, adult day health, PERS monitoring, transition coordination, transition services)
 - Consumer Directed (personal care & respite)
 - Nursing Facility
- Behavioral health providers (CSBs and private providers)
- Medical Providers (Medicare)
- Pharmacy (Medicare)

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Pharmacy and Medical Services

- Pharmacy Providers (Medicare)
 - Submitted to and reviewed by the Centers for Medicare and Medicaid Services (CMS)
 - Must meet Medicare Part D standards
- Medical Providers (Medicare)
 - Medical provider networks will be submitted to CMS and reviewed at the federal level
 - Networks Specialty type and county geographic designation (e.g., large metro, metro, and micro, rural)

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Tailoring Services to Meet the Needs of Medicare-Medicaid Enrollees

Population	Program Strategies and Benefits
Individuals with physical disabilities	<ul style="list-style-type: none"> • Access to specialists and primary care providers with offices that are disability-accessible (including exam tables, scales, equipment, and offices); and • Access to providers who have expertise and experience serving people with physical disabilities.
Individuals with communication limitations	<ul style="list-style-type: none"> • Availability of member materials in accessible formats (e.g., Braille, audio, large font, compact disc, digital, reading-level appropriate, etc.); • Availability of bi-lingual materials and interpreters; • Availability of sign language interpreters to participate in appointments; • Access to assistive listening devices during appointments; and • Providing TTY and Relay telecommunication services for the deaf.

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Tailoring Services to Meet the Needs of Medicare-Medicaid Enrollees

Population	Program Strategies and Benefits
Seniors	<ul style="list-style-type: none"> Access to providers knowledgeable about geriatrics; Involvement of and training for family or community caregiver as requested; and Knowledge of social and community engagement opportunities.
Individuals with behavioral health needs	<ul style="list-style-type: none"> Access to specialist and primary care providers knowledgeable about working with individuals with behavioral health needs; Access to peer supports and non-traditional providers; Access to community integration activities such as clubhouses, social and recreational activities, and supports for independent living.

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LTC and Behavioral Health Networks

- Travel time and distance to appointments
 - 30 minute maximum travel time?
 - Rural, Northern Virginia, Urban differential?
- Choice of providers
 - E.g., is choice of 2 providers *always* appropriate?
- Consumer Direction
- Other priorities for providers

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Advisory Group Recommendations



Feel free to submit additional recommendations to:

dualintegration@dmass.virginia.gov

by December 3, 2012

Thank you

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Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

Stakeholder Education and Outreach

November 15, 2012

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Education and Outreach


(prior to enrollment in Demonstration)

- Education and outreach activities will begin in 2013.
 - Demonstration will launch on January 1, 2014 (open enrollment will begin October 15, 2013).
- DMAS is in the process of developing an education and outreach plan.
 - Fact sheets, regional trainings, Medicaid Memos, telephone conferences, WebEx, website updates, recipient letters, etc.
 - Receiving technical assistance from national experts on how to effectively communicate messages.

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Education and Outreach


(prior to enrollment in Demonstration)

- Plan to leverage partnerships with providers, community organizations, local partners, other state agencies, etc.
- Collaborate with health plans, when appropriate.

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Education and Outreach


(after enrollment in Demonstration)

- Ongoing stakeholder education & outreach will be critical.
- CMS is working with a subcontractor to develop a series of beneficiary notices, letters, forms, etc.

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Education and Outreach

(after enrollment in Demonstration)


- Enrollment broker and Ombudsman will play a role in beneficiary education.
- Search for possible grant opportunities to assist with education and outreach.

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5



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Advisory Group Recommendations


- Best modes of communication to reach various stakeholder groups?
 - Beneficiaries (e.g., letters, health fairs)
 - Families/caregivers (e.g., health fairs, public forums)
 - Providers (e.g., Medicaid Memos, public forums, press releases, provider letters, webex)
 - Community organizations (e.g., e-mail, fact sheets, website, trainings)
 - Local partners (e.g., e-mail, website, trainings)
 - Other state agencies (e.g., e-mails, website, trainings)

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6




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Advisory Group Recommendations

- Timing of outreach efforts?
 - Mornings
 - Evenings
 - Weekends
- Additional recommendations?

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Advisory Group Recommendations

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by December 3, 2012

Thank you

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Financial Alignment Demonstration to Integrate
care for Individuals Eligible for Medicare and
Medicaid

Quality Assurance

November 15, 2012

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CMS Core Measures

- CMS is prescriptive on quality measures related to acute care and pharmacy services;
- states can submit measures related to Medicaid services (long term services and supports, behavioral health etc.).

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Seventy core measures required by CMS:

- **Special Needs Plan (SNP) Measures related to the Model of Care:**
 - SNP is a Medicare Advantage plan that enrolls a sub-set of Medicare-eligible individuals, e.g.
 - Special needs SNP;
 - Chronic conditions SNP;
 - Institutional SNP;
 - **Dual eligible SNP;**

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SNP Model of Care

Eleven Point Program that MCOs must submit to CMS that describes how they will deliver care:

1. Define the populations and explain the following for each:
2. Measurable goals (improve: access, seamless transitions, care coordination, use of preventive services);
3. Staff structure and care management roles;
4. Interdisciplinary care teams;
5. Provider network with specialized expertise;

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SNP Model of Care, cont'd.

6. Use of health risk assessment;
7. Individualized Care plan;
8. Communication networks connect plans, providers, individuals;
9. Oversight of communications effectiveness;
10. Add-on services;
11. Performance and outcome measurement – how MCO collect, analyze, report, evaluate the Model of Care;
- 12. Optional state-selected measure.**

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5



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Identified Populations


- Individuals enrolled in the EDCD waiver;
- Individuals with intellectual and developmental disabilities;
- Individuals with serious and persistent behavioral health issues;
- Individuals with end stage renal disease;
- Individuals with other serious or multiple chronic health care needs; and,
- Individuals at high risk of hospitalization.

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6




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SNP Model Of Care quality measurement

- CMS reviews MCO documentation to determine:
 - The MCO coordinates services for members with complex conditions and helps to access services;
 - Coordination of Medicare and Medicaid benefits;
 - IDs problems that could cause transitions, prevents unplanned transitions, etc.

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CMS Core Measures, cont'd.

- Medicare Part D Measures:
 - Pharmacy hold time;
 - Foreign language interpretation;
 - Appeals auto-forwarded (plan did not meet deadlines for timely decisions);
 - Appeals upheld;
 - Complaints about drug plan;
 - High risk medication when may be safer drug choices;
 - Diabetes, hypertension, cholesterol treatment.

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CMS Core Measures, cont'd.

- Consumer Assessment of Health Plan survey (CAHPS) measures:
 - Access and satisfaction;
 - Experience of care;
 - Customer service;
 - Getting information from drug plan;
 - Getting needed prescriptions;
 - Getting appointments and care quickly;
 - Access to specialists;
 - Help with transportation;
 - Outcomes for behavioral health;
 - Cultural competence, etc.

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CMS Core Measures, cont'd.


- HEDIS Measures:
 - Initiation of substance abuse treatment;
 - Follow-up after MI hospitalization;
 - Antidepressant medication;
 - Transition record transmitted to providers;
 - Medication reconciliation after discharge;
 - Older adults medication review;
 - Functional status assessment;
 - Pain screening;

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CMS Core Measures, cont'd.

- HEDIS Measures, cont'd:
 - Diabetes care (eye exams, kidney function test, blood sugar control);
 - Rheumatoid arthritis management;
 - Readmissions;
 - Reduce fall risk;
 - Control BP;
 - Preventive health screenings;
 - Flu, pneumonia vaccines;
 - Access to primary/specialist care.

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CMS Core Measures, cont'd.

- Nursing facility residents with pressure ulcers (National Quality Forum);
- Part D appeals times (Independent Review Entity);
- Comprehensive Medication Review (Pharmacy Quality Alliance);
- State defined measures:
 - Completed assessments;
 - Individualized Care Plans meet all needs;
 - Hospital admission notification;
 - Risk stratification using BH/LTSS indicators;
 - Time to follow up visit after discharge.



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DMAS Measures

- Long Term Services and Supports
 - May need to include some measures required by the Elderly and Disabled with Consumer Direction waiver:
 - Other process measures:
 - Validate that individuals meet Level of Care criteria;
 - Annual reassessments performed;
 - Service plans updated as required;
 - Individuals offered choice between institutional and home-based services;
 - Providers meet qualification requirements;
 - EDCD provider training conducted;
 - MCOs ID and address abuse, neglect, exploitation.



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CMS External Evaluation

- CMS contracted with an evaluator to conduct a study of the demonstration, both on a national scale and state-specific. Specific measures unknown, but they will include analysis of utilization data and costs.



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Advisory Group Recommendations

- Given the large number of CMS-required core measures, need to be judicious and select state measures that are most salient.
- Do core and LTSS measures seem sufficient?
- Should DMAS require a 12th optional Model of Care Measure? If yes, what should it be?
- What other state measures should be included, if any?

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Advisory Group Recommendations

Can also submit additional written recommendations to:

dualintegration@dmas.virginia.gov

Please provide additional written recommendations by December 3, 2012

Thank you

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